STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005020	A. BUILDING: _____ B. WING _____	05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW REGIONAL MEDICAL CENTER	11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The survey was for investigation of a State hospital complaint. Complaint Number: IN 00170107 Unsubstantiated: Lack of sufficient evidence. Date: 5-21-15 Facility Number: 005020 Parkview Regional Medical Center is in compliance with 410 IAC 15-1.6-2, Emergency services, Indiana Hospital Licensure Rules. QA: cjl 06/09/15	S 000		